

inhalation therapy

December 1961

Volume 6 Number 6

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The Final Story on the Workings of

A. A. I. T. Headquarters

The Importance of

Safety

The Complete Story of the

Buffalo Meeting



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References: (1) Cole, M. B., and Raynolds, A. H.: South. M. J. 54:17 (Jan.) 1961. (2) Reinetti, Jr., A. D.: Bull. Nat. Tuberc. A. 47:7 (April) 1961. (3) Kaufman, M., and Kaplan, M. P.: J. Kentucky M. A. 59:251 (Mar.) 1961.

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VOLUME 6 NUMBER 6

inhalation therapy

DECEMBER 1961

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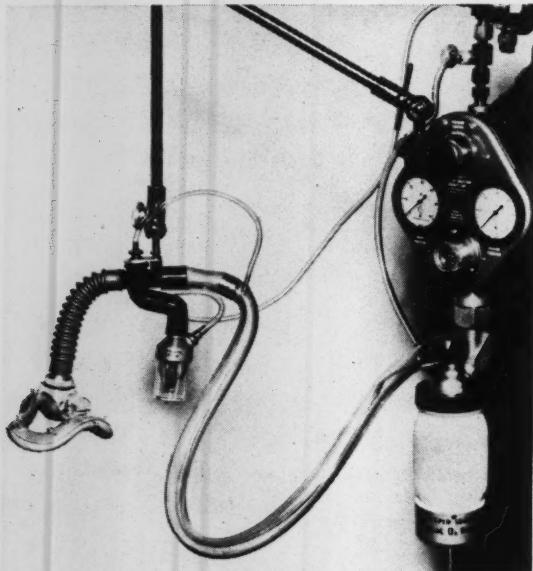
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Considerations in Humidification by Nebulization:

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Diseases of the Chest, Oct. 1958, Vol. XXXIV, No. 4.

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Pulmonary Emphysema:

Hurley L. Motley, MD.

Missouri Medicine, June 1960, pp 701-709.

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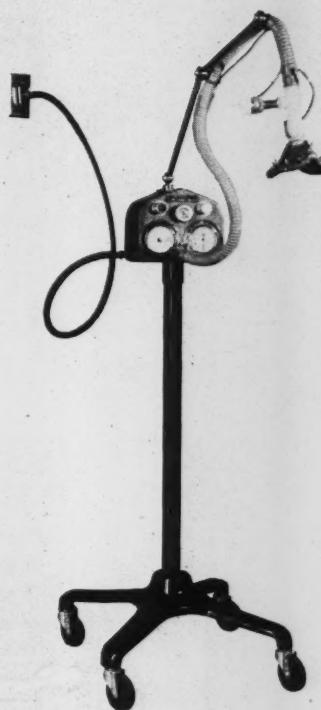
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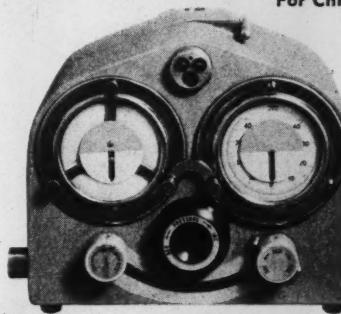
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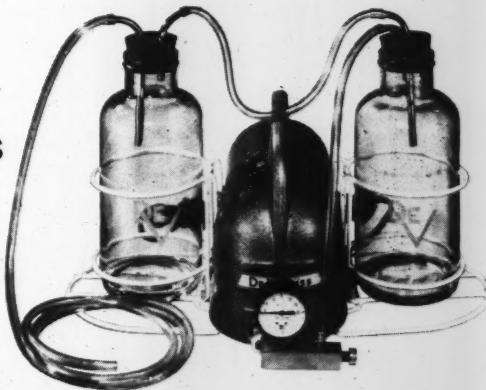
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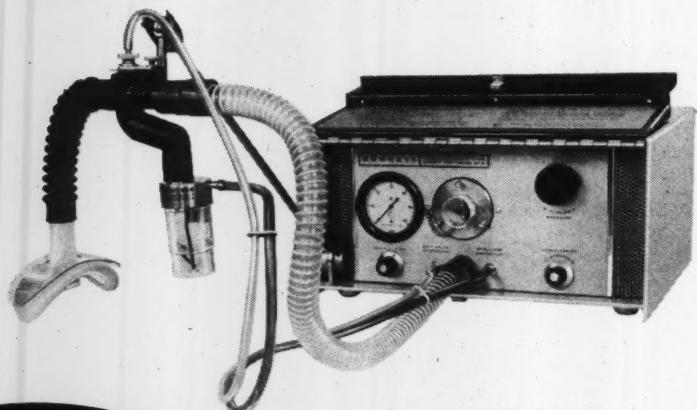
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President's Acceptance Speech

TO say, "thank you colleagues," cannot really express my sincere appreciation of the honor you have given me. I would not presume the privilege of expressing humility before you either, for I believe as Paul Eldridge did, that "true humility is possible only for the greatly successful;" and he continued with saying, "even the tallest mountain knows how far it is from the sky."

Today we who are the A.A.I.T. are celebrating our seventh birthday. If some of our retired but still esteemed and honored leaders could have been here at the meeting which is just closing, I'm sure they would rejoice, as do all of you who are still going strong, that many of the dreams that seemed utterly impossible at the Organization Meeting have now been achieved.

Many of you remember the early Annual Meetings when we were all inspired by our mutual will to gain a goal. Why, at those meetings many seemed to have "the strength of ten;" but when we got home again we found our strength comparable to that of, "the Prophet in the land of the deaf;" and we thought over and over again, "it's impossible; I can't do that." Then having rationalized that an impossible goal had been set, we settled back into our same old ruts. Many of us then seemed to hear a small but clear voice saying, "is it really impossible?"

Many heard that call, but comparatively few heeded it, or realized that it might be the voice of God saying, "open the door: I am hereby giving you the opportunity to grow inches, or feet, or miles, whichever your capacity may be. I am bidding you to make ready to give help, and perhaps bring blessed healing to my gasping children."

Those of you who heeded that call worked long and hard to bring the A.A.I.T. and the A.R.I.T. into successful being. You knew that the intervening hurdles were insurmountable, and your friends all knew that the things that you proposed to do were impossible; but somehow you were guided to know that the only possible way to succeed was straight through the middle of the impossible.

I leave to you the privilege of reflecting on the many impossible goals that the A.A.I.T. has achieved during the last seven years.

Mr. President, I know that I speak for the entire membership in thanking you and all of your predecessors for your excellent leadership, and your many accomplishments in your organization's best interest.

Members at large: I hope that you will be able to retain much of the lore that you have been exposed to during the past few days, and all of the enthusiasm that you have engendered in communion with your colleagues.

Standing Committee members: I pray that you will continue, during the coming year, in the same degree of selfless dedication to A.A.I.T. that you have shown in the past.

Board of Directors, and Fellow Officers: I invite your continued inspiration in directing the progress of the A.A.I.T. toward its goal.

Members of the Board of Advisors: I deem it one of my life's greatest privileges to have been chosen by my colleagues to receive your council, and as their President to act on it.

To all of you I pledge my heart, my energy, and my ideals to serve and to guide you during the coming year.

Once again I want to thank you! I am well aware that many of you fully deserve to have received this honor today; and I pray that I will bring you the report of still another great and successful year at the next annual meeting. I want only to add that at that time I hope none of you will feel constrained to say, "she rested on her laurels;" for I am in full agreement with the adage which states: "The only person who can rest on his laurels is wearing them in the wrong place."

—Leah Tharaldson

Your Association – And How It Operates

THIS is the fourth and final article in the series explaining how your association operates.

In the first three articles an effort was made to outline the duties of the Secretary and of the Convention Manager, both assistants to the Executive Director, as well as to indicate the work done by the Executive Director himself.

In this article, the contributions made by some other individuals and groups will be discussed briefly.

First, consider the job of Mrs. Agnes Forrest, our Secretary-Treasurer, who has served in that position over four years.

In addition to counter signing all A.A.I.T. checks, Mrs. Forrest gives a great deal of her thought, time and energy to running the financial part of each annual meeting. For it is she who accepts all

money for registration charges, meals, dues, and/or processing fees paid during this one week every year. This is not exactly a "fun job", since it means being "on tap", as it were, for the entire meeting. So when you see Mrs. Agnes Forrest with her little green-gray cash box, and her books of receipts and strips of luncheon tickets, remember that she is performing an important job so that you members can enjoy a smoothly-run and efficient meeting.

After the annual meeting, Mrs. Forrest prepares a complete report of all receipts, and then files this report along with her receipts and bank deposit slips at national headquarters so that the auditor may have access to the records for our annual audit.

Another important job is the work performed by the members of the Admissions Committee. During the past year, Joseph Klocek, A.A.I.T. President, served as Chairman of this important committee. Mrs. Grace Farley, an A.A.I.T. Board Member, served as the second member of this committee.

Both these people have done a remarkable job of screening applications. Many letters have been written by them to applicants and/or their sponsors and references. This is often necessary, either because the applicants have not completely filled out the application, have not provided proof of their high school education, or, as sometimes happens, given information of a doubtful nature.

As I write this, the number of applicants rejected for various reasons does not come to mind. However, it is rather high, especially when you consider that the A.A.I.T. wants new members.

There are other committees, all of them



Mrs. Agnes Forrest, AAIT Secretary-Treasurer.



Mrs. Grace Farley of the Admissions Committee.

important, in fact, vital to the operation of the A.A.I.T.. They are as follows: Education, Industrial Advisory, Judicial, Nominating, Publications, Safety, Oxygen Service, Research Information, and Membership Promotion.

While we cannot go into detail about the functions of every committee, it may be worth mentioning the work of several.

The Research Information Committee, for example, is headed by Mrs. Leah Tharaldson, a member of the Board of Directors, and a tireless worker. Assisting her on this committee are the following: Vincent J. Collins, M.D., Don Gilbert, James F. Whitacre, Ross Hawkes, Vincent Kracum, J. Howard Newell, and George R. Hight.

The important Safety Committee had died a slow death during the last several years. Its importance prompted us to revive it, and to turn its Chairmanship over to a chap we knew would really *do something*. This was Richard M. Conover, who has re-organized the Safety Committee, and intends to make a real contribution. Assisting Mr. Conover are the following: Max Glasser, Gareth Gish, Clarence Troublefield, George D. Cranton, and Paul V. Chaballa.

Mrs. Vera Arguien is Chairman of the Membership Promotion Committee, and has as members of her committee the following: Leonard Gurney, Charles Rheinheimer, Joseph C. Purvis, Jr., Francis Bryant, Harold Singer, Clifford Hall, Jr., Wil-

liam Carey, John J. Viers, Walter Palmer, John Appling, Easton Smith, Bob Kratz, Gary Miller, Evelyn Kwit, Sister M. Arnoldine, Ruth Bumgarneo, Theodore London, Catherine L. Marler, L. Ernest Reynolds, Samuel Runyon.

Because of the important job this committee has to do, there is no question that other members will have to volunteer.

The greatest difficulty faced by our committees is simply that of getting together for meetings. Since we have just the one annual meeting, the conscientious chairman will make it a point to have one or more meetings during that week. For the most part, our committees have to function via the mail, and with so many people having full-time jobs and no secretarial help, this is not easy. Nevertheless, our committees have performed rather creditably, when one considers all things involved, and it is this working committee structure which we must strengthen for the future.

The hardest working group involved in the operation of the A.A.I.T. is, oddly enough, a group of outsiders. I refer to our Advisory Board, which while not a committee does function like one. Consisting of six physicians, three from the American College of Chest Physicians and three from the American Society of Anesthesiologists, the Advisory Board, as explained in a previous article, controls all matters of policy and public relations.

Were this not so, and the decisions of the A.A.I.T. Board of Directors not subject to the scrutiny and approval or disapproval of the six physicians, we would not enjoy the sponsorship of either the American College of Chest Physicians or the American Society of Anesthesiologists.

Some members have complained about this, indicating that such an arrangement makes the A.A.I.T. a captive organization.

This is not the entire truth, however, for the only purpose in having this control is to guarantee that the Board of Directors shall not make any decisions contrary to accepted ethical and professional conduct. Since so much of our

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Safety—First, Last, Always

Richard M. Conover*

FROM the time that oxygen was first used, there has been a certain degree of danger in its use. Fires and explosions have been associated with oxygen, and the danger has not been decreased through the years.

Granted, a considerable amount of progress has been made towards the elimination of accidents with the use of oxygen, but not enough. The two big questions we should ask ourselves are: "As therapists are we doing everything to prevent such accidents?" and, "Is the public being properly informed on this subject?"

These problems can be approached from many angles. One solution could be a scientific exhibit illustrating the problems associated with oxygen and its use. This exhibit could be used at medical and professional conventions throughout the country. Another solution could be to launch a nation-wide safety campaign which would include seminars in schools of medicine and nursing as well as meetings in cities and towns to acquaint the public with this major problem.

The American Association of Inhalation Therapists (AAIT) as well as each of its numerous chapters has a safety committee. This committee is charged with the duty of attempting to prevent severe accidents. This can be done in only one way, and that is with the cooperation of each member of the Association. Any incident, regardless of its magnitude, should be reported to the safety committee. When this is done an analysis of the accident can be made, and in this way the events leading up to the incident and ways of preventing its happening again can be determined.

Whenever an accident occurs, either from the use of oxygen or from any other cause, most people seem to think it is the result of faulty equipment. This is not always the case. It could be said that over ninety-five per cent of the accidents that occur are due, not to mechanical, but to human failures. If we, as therapists, would double our efforts, both in our own departments and in our teaching capacity, many of these accidents could be prevented.

Not long ago someone gave a patient in an oxygen tent a package of cigarettes and matches. The result was seventy-five per cent burns over the patient's body which eventually caused his death. This incident is mentioned to point out the need for a more intense drive in both education and in the formation of departments in hospitals which now have none. Had the hospital where this accident occurred had a department of oxygen therapy in operation, perhaps this disaster

*Supervisor, Inhalation Therapy, Duke University Medical Center, Durham, North Carolina; Chairman, Safety Committee, American Association of Inhalation Therapists.



could have been averted.

The case mentioned is just one of many that cause needless loss of life and equipment. Certainly a large percentage of these are minor; however, this does not lessen their importance. In the past, hospitals which used "K" type oxygen cylinders concurred in the use of straps or chains in securing the cylinders to a patient's bed. As long as the oxygen traffic was at a minimum, this was satisfactory. In the present age, however, it is not. One suggestion that is being put into effect in a southern medical center is the fastening of a wooden bar to the wall, with toggle bolts, from thirty-six to forty inches from the floor. A heavy duty chain which will fit around the cylinder is then attached to the bar. (See fig. 1) When a regulator and tubing is placed on the cylinder and the equipment put into operation, it is very difficult to turn the tank over. When it is time for the cylinder to be changed, the

patient does not have to be needlessly disturbed, for the entire change can be made without the patient's ever knowing. Should the patient's bed need moving, the danger of turning the cylinder over has been removed since it is not attached to the bed.

This is just one example of what can be done towards removing hazards. There are many pamphlets, brochures, and papers that have been written on the subject of safety. Unfortunately, not every department has a reprint file, which should be essential.

Ciliberti and Wood¹ mention that thirty-two cases of explosions were the direct result of static electricity, and in the majority of these cases it was found that there was little or no grounding of the equipment. While *these cases were concerned with anesthesia gas-oxygen mixtures rather than oxygen-air mixtures*, wherever a high concentration of oxygen is being maintained, grounding of equipment is essential. The equipment now on the market, for the most part, has a ground wire included in the electrical system. However, all too often, some one has an electrical outlet that does not have the ground wire built in. When this happens, rather than obtaining an adapter, they simply cut the grounding pole off of the plug. This is just courtting trouble. Rather than cutting the pole, replacement of the wall outlet is desirable.

Reduction of electrical hazards and the use of conductive equipment werever possible is heavily stressed by Gilroy². When planning a department either in an existing or in a new hospital, the safety factors should always be near the top of the list. It should be remembered that gaseous fires and explosions are not restricted just to hospitals. This is shown emphatically in A. E. Miller's³ article on the use of oxygen in aircraft. It was pointed out by Mr. Miller that a totally leak-proof circuit is needed. The enormous danger encountered when transfilling cylinders is also brought out in his article.

Much emphasis is placed on the fact that oxygen will not burn. What should be emphasized is the fact that oxygen supports combustion, and that a combustible

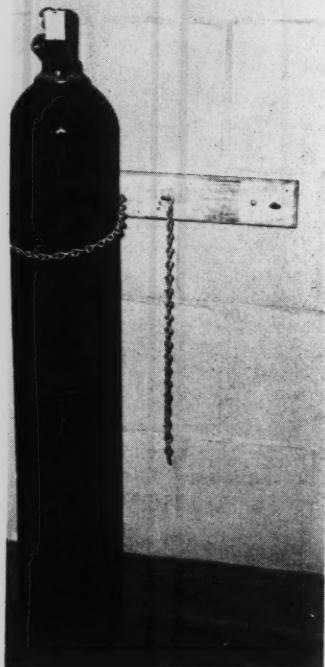


FIG. 1

material in the presence of oxygen will burn vigorously. If a demonstration on the use of oxygen with a combustible material is used, this gets the idea across. An ordinary cigarette can be used here. After lighting it, the cigarette is then introduced to flowing oxygen, as from a piece of rubber or vinyl tubing. The cigarette will immediately flare up, giving a vivid demonstration.

In his manual for prevention of fires and explosion, Dr. George Thomas⁴ points up the necessity of having proper handling and storage facilities for compressed gases. One of the most important items included is the draping of gowns, bags, masks, etc., on cylinders of oxygen and other gases. I think that this is one of the easiest ways known to start a flash fire, especially if the temperature is exceptionally high. All too often this is being done, not with a deliberate knowledge of doing wrong, but simply because it may lighten the load being carried and the cylinder is handy. So often this is seen and not corrected at the time. A few seconds is all that is needed to start a fatal fire or to cause an explosion.

Several months ago a survey was made of all manufacturers of oxygen equipment and gases. One of the interesting replies was from a Swedish firm concerning regulators and fires involving them. After a number of instances of fire had occurred, the source was finally traced to some of the internal parts of the regulators. These parts were diaphragms and packings made of rubber. By using parts made of another substance, one that is not combustible, the instances were reduced.

Another case resulted from using an oxygen regulator on a cylinder of compressed air that had been filled by an oil-lubricated compressor, and afterwards using it on an oxygen cylinder. This demonstrates the necessity of keeping separate the regulators used on different gases. The importance of using non-oil base lubricants is shown in a case of a regulator catching fire. Upon inspection, grease particles were found to have entered the regulator. Probably the grease was on the cylinder valve and was injected when the regulator was used.

For a rapid reference in p.s.i. of cylinders at various temperatures and appropriate weights and dimensions many sources can be drawn upon.^{5 6 7 8 9 11} There is also a simple way, used by many, to determine the length of time a K cylinder will last. The formula is:

(Cylinder contents (P.S.I.) x 3) ÷ Liters per Minute = The Number of Minutes the Tank will last.

An example would be:

$$1500 \text{ lbs. p.s.i.} \times 3 = 4500.$$

$$4500 \div 15 \text{ L/min.} = 300$$

$300 \div 60 = 5$ hours, the time the tank will last.

It should be remembered that the above formula is used for cylinders with a 220-244 cubic foot capacity. When the duration of an "E" cylinder is desired, multiply the pounds pressure by 0.3; for "D" cylinders 0.16 is used; and for "G" cylinders 2-2/3." The factors in these formulae are actually a bit higher than indicated here. However, use of the existing factors allows for a safety margin.

Although there are usually twenty to thirty minutes of oxygen remaining in a K cylinder after the gauge indicates 'empty,' this should definitely not be relied upon. In many cases when students have been told of this reserve, it has been found that they are relying on this should they forget to change the tank soon enough. The only drawback is that it is not always known when the needle hits zero; this can result in the patients' running out of oxygen. Therefore, it is suggested here that the habit of telling students and others of this reserve be stopped since all too frequently the reserve is not what one believes it to be.

In summary, four primary items are brought to mind. The first: a complete nation-wide education program; this to be accomplished by a scientific exhibit and seminars in medical and nursing schools. Second: a more intense safety campaign directed to the public as a whole. Third: complete cooperation with the Safety Committee of the American Association of Inhalation Therapists; this to be done

continued on page 26

Professionalism Stressed at Buffalo Meeting

Forty therapists take Registry orals; thirty-two granted registration.

Mrs. Leah Tharaldson is new president;
Joseph Klocek, chairman of the board.

by James F. Whitacre

SIX of our 16 speakers this year placed major emphasis on professionalism in one aspect or another. Now that we have Registry, our members are striving not only to improve their knowledge qualifications, but also to develop the elusive, though highly desirable attributes of the professional.

In discussing "Internal Public Relations," Dr. Hylan A. Bickerman, of Columbia-Presbyterian Hospital in New York, carefully outlined the interrelations of the therapist with the patient, the nursing and medical services and the administration. One of the chief things distinguishing the professional therapist from an unprofessional technician is his ability to combine good communication and thoughtful, ethical conduct with technical excellence.

At the Monday luncheon session, Dr. Vincent J. Collins, of Cook County Hospital, Chicago, told the group that "a profession may be described as requiring dedication. The watching of the clock is not involved . . . It is guided by a code of ethics—which basically is a practical interpretation of the Ten Commandments."

Mr. Abraham Lister, of Shor's Medical Oxygen Service, Elizabeth, New Jersey, in describing service companies and their activities, stressed the importance of the therapist's relations with the patient and his family, and with the physician, whom he often represents to the family. The necessity for the professional to master all technical matters was also mentioned, but as a foregone conclusion.

Dr. Franz Reichsman, of the University Medical Center, Rochester, N. Y., dealt with the need to understand the patient and his reaction to his illness, the need to be a good listener and to make explanations and reassurances where possible, and to know when and how to refer the inquisitive patient or his family to the physician. Other cardinal points he underlined were the necessity for absolute confidentiality, and the care that should be taken to prevent a patient's hearing (or hearing *about*) staff disagreements regarding diagnosis, therapy or prognosis.

In his address to the membership at the Annual Report luncheon, Albert Carriere, Executive Director of the AAIT, reiterated the need for a strong professional attitude, which includes the courage to recognize unethical practices and to do everything we can to stamp them out. It is not enough, he said, just to ignore or not participate: counter action should be taken, and the proper authorities notified.

One of the features of the first annual banquet was the presentation of an award to Sister Mary Yvonne, CRNA, of St. Francis Hospital, La Crosse, Wisconsin, for her long and distinguished service to inhalation therapy. In addition to serving on the Board of Directors, Sister Yvonne is author of our magnificent Code of Ethics. She is currently the Registrar of the ARIT. The award plaque was presented by retiring president Joseph J. Klocek, RN.

Another highlight of the banquet was

the inspirational address by Dr. Everett Baker, of St. Joseph's Infirmary, Louisville, Kentucky. Dr. Baker helped us to see that neither the patient, the doctor, the nurse, nor the therapist can do the job without God's help. He pointed out many of the wonderful things we need not only to be thankful for, but to keep in mind to help us in our most important mission of good patient care.

At the meetings of the Registry Board during the convention, two important things were accomplished. First, 32 therapists were registered after having successfully completed written and oral examinations (see list in box elsewhere in this issue). This brings the total number of registered inhalation therapists in the United States and Canada to 68. Second, steps were taken to make it possible for Service Company members with proper medical supervision to apply for registration (not heretofore permitted).

The Advisory Board, in reviewing some events which have occurred in recent months, recommended that some additions be made to our Code of Ethics, to make it more unmistakably clear that it is unethical for therapists to receive commissions or gratuities for equipment which has been sold as a result of their recommendations; or to accept favors in return for promotion of certain products to the exclusion of others.

Dr. Albert H. Andrews, Jr., of Presbyterian-St. Luke's Hospital in Chicago, was first speaker of the meeting, and told the standing-room-only audience of their responsibilities in keeping equipment in top condition—of testing the *testing* equipment to check its accuracy, and of ways to adapt apparatus for special applications.

The next morning, "The Role of the Inhalation Therapist in Resuscitation" was elaborated by Dr. Duncan A. Holaday, of the University of Chicago Medical School. Dr. Holaday's extensive demonstrations of mouth-to-mouth artificial respiration and closed-chest cardiac massage—both done on a special manikin—were enthusiastically received, and the questions were so numerous they had to be stopped to keep the meeting on schedule.

"Logistics of Inhalation Therapy" was the topic of Dr. Meyer Saklad, of Rhode Island Hospital, Providence, that afternoon. Dr. Saklad stated that the only way for a department to function effectively is for the personnel to know everything about their equipment and techniques, and to have a carefully planned communication system with each other and with other departments, so that properly functioning equipment and personnel can be "in the right place, in the proper quantities, and at the right time."

Dr. Theodore H. Noehren, of the University of Buffalo Medical School, spoke on "Factors Influencing the Effectiveness of IPPB," and described some extremely interesting studies of ventilation in dogs using an ether clearance technique, which demonstrates the effect of the presence or absence of airway obstruction on air flow and other variables of respiratory aerodynamics.

Dr. Jerome Maurizi, also of the U. of Buffalo Medical School, then talked about the "Treatment of Carbon Dioxide Intoxication." He gave a description of the development of the syndrome, and the pathophysiological blood changes associated with it; then progressed to the treatment. Dr. Maurizi is of the opinion that such patients should be ventilated (automatically, if necessary), and that if this is maintained, oxygen may be given to relieve hypoxemia as needed, without worry about apnea.

Wednesday's session opened with Dr. Robert M. Lawrence, of the University of Rochester (N.Y.) Medical Center, speaking on "The Use of Specialized Equipment." Dr. Lawrence showed a color film depicting the treatment of a crushed chest injury with an automatic ventilator, and discussed paradoxical respiration and other problems associated with this sort of injury and with other patients requiring specialized apparatus and skills for successful management.

Sister Mary Antonella, Administrator of St. Joseph's Infirmary, Louisville, Kentucky, then gave her views of "The Administrator and the Inhalation Therapist." She traced the history of inhalation therapy over the past 25 years, then showed



Frank Huston and James Whitacre talking with new president Mrs. Leah Tharaldson.



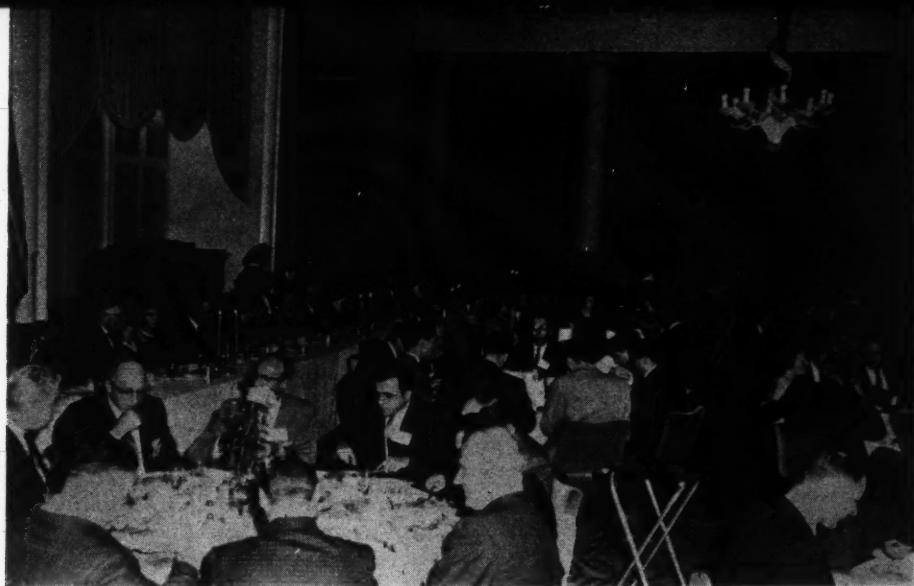
Service member Mr. Abe Lister and Mrs. Lister.



Mrs. Agnes Forrest greeting Dr. Leon Abundio V. of Mexico as Mr. Carriere and Mr. Abram Jackson look on.



A picture of the Nun's Get-Acquainted Hour which preceded the banquet.



A panoramic view of the banquet.



Emil Stary, registered therapist, provided piano music during the Get-Acquainted Hour.



Joseph Klocek presenting award citation to Sister Yvonne.



Albert Carriere talking with Dr. Everett Baker guest speaker at the banquet.



At Get-Acquainted Hour from left to right, Jack Sanger, Mrs. Joan Grayson, Gordon Eaverson.

the Administrator's interest in promoting teamwork among doctors, nurses and therapists, to effect better patient care. She suggested that introspection and prayer would never be amiss in helping the therapist become more dedicated to his job of helping the sick.

"The Use of Simple Pulmonary Function Testing" was treated by Dr. Howard G. Dayman, of the University of Buffalo Medical School. Dr. Dayman gave an analysis of spirometry, and showed by many slides how spirograms made with fast-moving drums could be used to show many useful things about the state of the patient's lungs. This is in contradistinction to spirograms made with conventional slow-moving drum spirometers, which give somewhat limited information because the record is not spread out enough to permit accurate analysis.

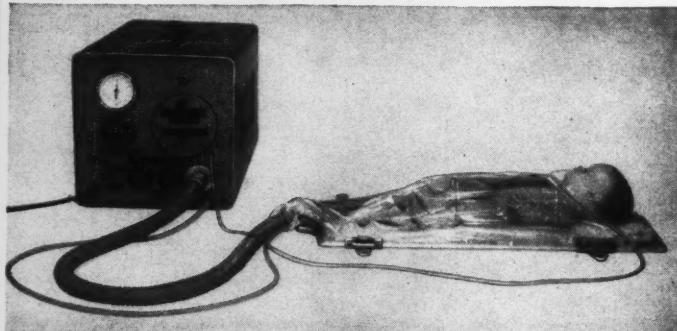
Captain Frances A. Parks, Army physiotherapist from Valley Forge General Hospital, Phoenixville, Pennsylvania, gave an enlightening talk on "Breathing Exercises for Pre- and Post-Operative Thoracic Sur-

gery Patients," which included valuable information (new to most inhalation therapists) about the muscles involved and what exercises can be done to strengthen them to help improve ventilation. Also, how to promote better ventilation of one lobe or another of the lungs by special exercises which she showed on slides and by demonstration. This was the first time we have had a physiotherapist on our program, and her information was both interesting and well-received.

The lectures were all tape recorded by the Education Committee, and are all already available from AAIT Hq. The Education Committee also wishes to announce the publication of a small "Educational Aids" guide, which includes listings of lantern slides, films and all of the tape recordings of the annual lecture series from 1956 through 1961. This booklet is also available from AAIT Hq, at cost: 25c. It is recommended that chapters and/or interested individuals make use of these aids in their education programs.

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Ruth Bumgarner
Miami, Florida
Paul Chaballa, R.N.
Elizabeth, New Jersey
Emil Cioffoletti
New Rochelle, New York
Joseph Clark
Ottawa, Ontario, Canada
Agnes Corcoran
Bridgeport, Connecticut
Leslie Freedman
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Gareth Gish
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George Jester
Trenton, New Jersey
Howard Justice
Nashville, Tennessee
Robert Knouse
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James Krupla
Clifton Heights, Pennsylvania
Desmond LeMesurier
Providence, Rhode Island
Theodore London
Chicago, Illinois
Eileen Lovelace
Gary, Indiana
Stephen Marich
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William McCluskey
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Robert Miller
Portland, Maine
Bill Edward Morrison
Kansas City, Missouri
Edgar Reabuck
Philadelphia, Pennsylvania
John Lakeland Rewis
Nashville, Tennessee
Lawrence Richmond
Westport, Connecticut
Hans Rubarth
Ottawa, Ontario, Canada
Levern Schaut
Buffalo, New York
Richard Shorell
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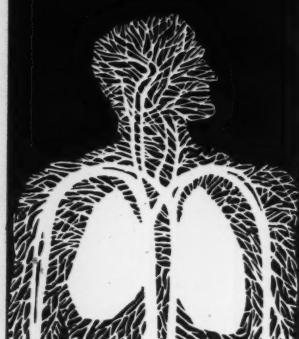
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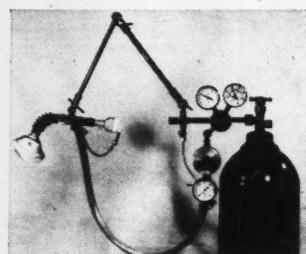
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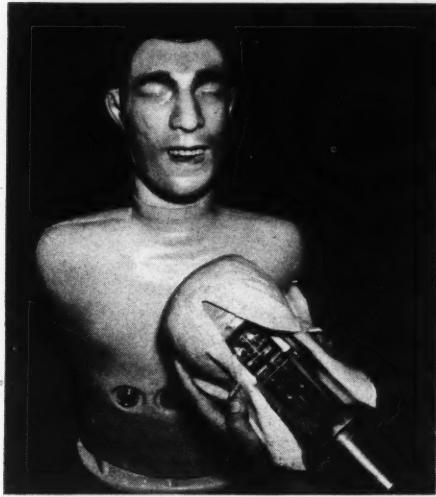
Cylinder Model

EQUIPMENT NEWS

(Information and photographs are supplied by the manufacturers or distributors.)

New training manikin

Alderson Research Laboratories, Long Island City, N.Y., has introduced a life-size manikin for teaching and practicing mouth-to-mouth resuscitation techniques. Surfaced with a plastic "skin" feeling like human skin, the RESPERTRAIN



manikin employs a valve system in its airway that makes it function like humans. If the head is incorrectly positioned, the lungs do not inflate because of the blocked airway, and the air is diverted into a "stomach" bladder. Correct positioning permits the "lungs" to fill as they should.

No. 661

Portable aerosol generator

Eliminating the need for canopies, masks or tents, the Air-Shields (Hatboro, Penna.) *Mist-I-Fier*, a centrifuge type aerosol generator, produces droplets averaging 8 microns in diameter at 3 feet from its output port. About 2½ quarts of water are aerosolized in 10 hours. This compact portable unit (weighs only 6 lbs.) can be placed on a bedside or overbed table close to



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continued from page 17

by reporting each incident so that it can be investigated and its re-occurrence prevented. The Safety Committee will in turn work with the safety committees of the other organizations that are striving to insure the security and welfare of our patients. Fourth: making existing information more readily available to all concerned. Which is most important? This cannot be answered, because they are all needed, perhaps with variations, but still needed.

The challenge is this: to make the medical profession, as well as the public, more aware of the dangers which lie in the misuse of oxygen. Can we meet this challenge? If not, then we are not living up to our obligations as therapists. However, I believe this challenge can be met; and we can do so because it *has* to be done.

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policy involves things of a medical nature, it is only fitting that we be guided by a group of doctors.

As a matter of fact, the writer can remember only two occasions when the Advisory Board used its influence to veto Board decisions. In both instances time has proven the wisdom of this action.

The commendable thing about the six doctors who comprise the Advisory Board is their complete and unselfish dedication to the A.A.I.T. and its affairs. Not only have these men given the A.A.I.T. a tremendous amount of time and energy and thought, they have each made quite substantial financial contributions, by paying their own travel and other expenses to meetings, and by taking large chunks of time out of their practice to help the association.

In addition to their duties as members of the Advisory Board, these same six men also serve as Board Members of the American Registry of Inhalation Therapists. The A.R.I.T. Board of Directors consists of the six doctors plus three members of the A.A.I.T., a total of nine.

They are as follows: Sister M. Yvonne, Registrar; Don E. Gilbert; James M. Whitacre, Secretary; Dr. Albert H. Andrews, Jr., President; Dr. M. Saklad, Treasurer; Dr. Edwin R. Levine; Dr. Vincent J. Collins; Dr. Duncan Holaday; and Dr. H. Bickerman.

The total amount of just man-hours that this group has put into the planning, formation, and operation of the Registry is simply staggering. Again, it should be emphasized, for all nine persons involved, the six physicians and the three inhalation therapists, this is entirely a *labor of love*. No one is paid; no one has ever received any recompense for time and work contributed. In fact, it would be impossible to measure in dollars and man-hours the contribution made by this group of dedicated people to the growth in dignity and stature of both the American Association of Inhalation Therapists and inhalation therapy itself.

All of us should be deeply grateful to them.

Now what about the future of the American Association of Inhalation Therapists?

How do our professional standards compare with those of other paramedical associations?

What does it appear that our growth will be during the next five years?

Since the writer is neither a medical doctor nor an inhalation therapist, it may seem presumptuous of him to express an opinion about these matters. Nevertheless, having nurtured the early life and carefully watched the growth of the A.A.I.T., and having carefully observed and worked with other comparable associations, perhaps a prognosis will not be out of order.

There is no doubt that over the next five years membership in the A.A.I.T. will increase substantially. Evidence of this lies in the increasing awareness of inhalation therapy, in the great number of inquiries about the Association, and the deluge of correspondence asking about eligibility.

From all indications, it seems likely that we shall increase the membership in the A.A.I.T. from its present 1200, approximately, to at least three thousand by 1964. This is a conservative estimate.

Hospitals throughout the United States and Canada are becoming more and more aware of the importance of inhalation therapy in better patient care. Increasingly, hospitals are establishing new departments of inhalation therapy.

In short, the American Association of Inhalation Therapists is likely to become a fairly large association chiefly because at long last inhalation therapy has come of age.

Well, there it is, the story about your association and how it operates.

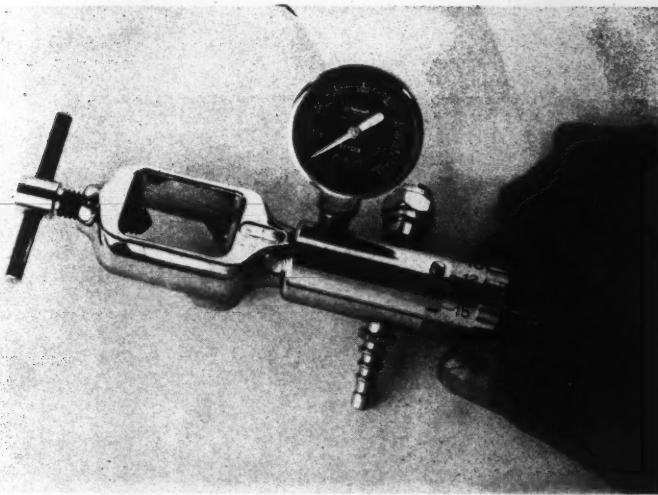
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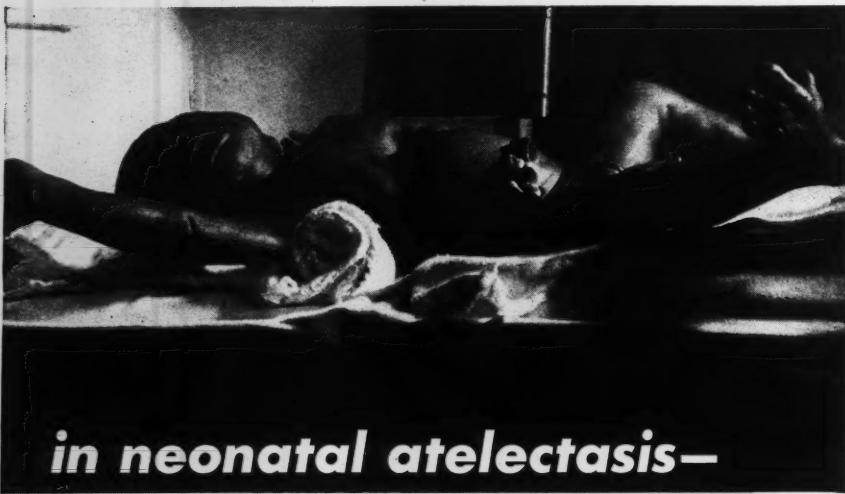
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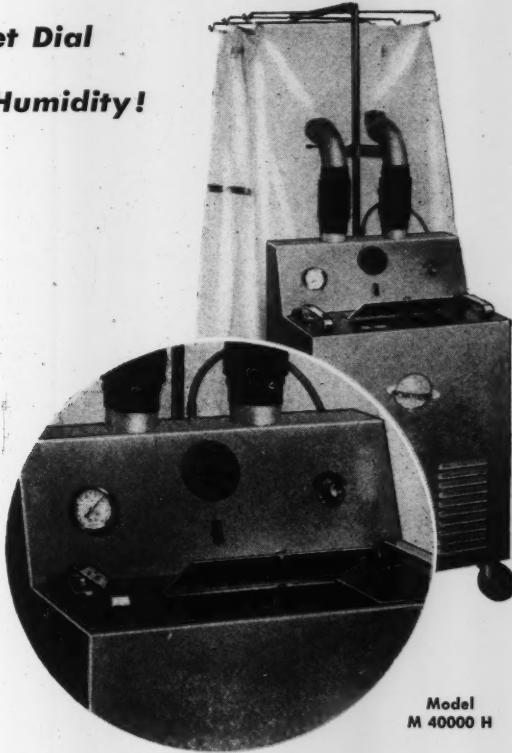
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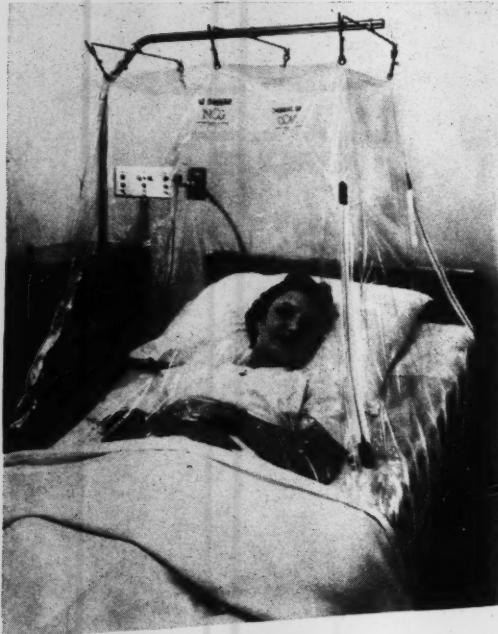
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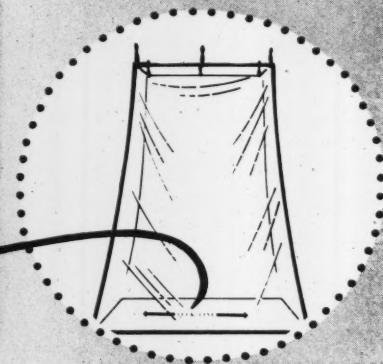
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